HIE Steering Committee

Medicaid Claims Pilot Subcommittee

Kick Off Meeting - March 2021

Agenda

- Discuss the Purpose & Goals of the Medicaid Claims Pilot Subcommittee
- Meet the Subcommittee Members
- Learn, What's in a Claim?
- Review the Use Case Gathering Process

VHIE Claims Pilot

Phase I: Medicaid Claims

- Premise: Aggregating demographic, clinical, and claims data is foundational to evaluate population health statistics and emerging value-based programs.

- *All-Payer ACO Model Implementation Improvement Plan*, "Consistent with the Health Information Exchange Strategic Plan, the AHS, VITL, the State HIE Steering Committee and the GMCB need to accelerate progress in making integrated claims and clinical health data available to providers."

Medicaid Claims Pilot

What is the VHIE/Medicaid Claims Pilot?

- A pilot to test the integration of claims data into the VHIE system.
- The pilot will focus on Medicaid claims data.
- VITL purchased a data management tool (Medicasoft) that has an established track record of integrating clinical and claims data.
- This year, the DVHA/VITL contract calls for the testing of an integrated clinical and claims data set.

What's the role of the VHIE/Medicaid Claims Pilot?

1. To articulate the use cases for integrated clinical and claims data, with a focus on Medicaid claims.
2. To aid VITL, and partners, in designing a technical solution for aggregating claims through the VHIE system.
3. To identify any legal or data governance needs for aggregating claims data through a new system.
4. To evaluate the pilot and aid in planning next steps.

What do we hope to accomplish?

- **Define & Prioritize Use Cases**
  - How will a user access claims data or linked clinical and claims data?
  - For what purpose do they need the data?
  - What authorizes their access to the data?
- **Identify Needed Policies**
  - What agreements/policies govern data aggregation, security, and access?
- **Safeguard Data Quality**
  - Relying on existing standards, establish criteria to ensure usability of aggregated claims data (Connectivity Criteria)
- **Develop Technical Requirements**
  - Based on use cases and data governance policies, develop technical system requirements
- **Implement Technical Solution**
  - *What is our measure of success? Meeting some or all of the use cases?*

VHIE/Medicaid Claims Pilot

Name, Organization	Role on Subcommittee
Lisa Schilling, DVHA, AHS	Medicaid Claims and Payer Operations SME
Ena Backus, Health Care Reform, AHS	Health Care Reform SME
Sarah Lindberg, Green Mountain Care Board	Claims Management/All-Payer Claims Database SME; Data Governance SME
MaryKate Mohlman, Health Care Reform, AHS	Health Data Research & Analytics SME; Data Governance SME
Erin Flynn, DVHA, AHS	Medicaid Payment Reform SME
Tim Tremblay, Health Care Reform, AHS	Blueprint for Health SME
Katie Muir, OneCare Vermont	ACO SME
Carolyn Stone, VITL	VHIE Technical Operations & Design SME
Beth Anderson, VITL	VHIE Policy and Governance SME
Emily Richards, Health Care Reform, AHS	Subcommittee Operational Support

Medicaid Claims Overview

Lisa Schilling, DVHA Chief Financial Officer

Claim Types

Code	Paper Claim Type	Electronic (EDI) Claim
M – Professional	CMS – 1500	ASC X12N 837P Version 5010
L – Dental	Dental	ASC X12N 837D Version 5010
O – Outpatient	UB-04	ASC X12N 837I Version 5010
I – Inpatient	UB-04	ASC X12N 837I Version 5010
H – Hospice	UB-04	ASC X12N 837I Version 5010
Q – Home Health	UB-04	ASC X12N 837I Version 5010
N – Nursing Home	UB-04	ASC X12N 837I Version 5010
X – Crossover	UB-04	ASC X12N 837I Version 5010
W – Crossover	UB-04	ASC X12N 837I Version 5010
Y – Crossover (Prof)	CMS – 1500	ASC X12N 837P Version 5010
D – Pharmacy and supplier transactions	-	NCPDP Version D.0

Adopted Code Sets

Activity	Standard
Diagnosis coding	ICD-10-CM—International Classification of Diseases, 10th edition, Clinical Modification
Hospital inpatient procedure coding	ICD-10-PCS—International Classification of Diseases, 10th edition, Procedure Coding System
Outpatient procedure and physician services coding	CPT—Current Procedural Terminology
Supplies/not included in CPT	HCPCS—Healthcare Common Procedure Coding System
Dental procedure coding	CDT—Code on Dental Procedures and Nomenclature

Electronic & Paper:

- Over 90% of claims are submitted electronically.
- Electronic claims are automatically loaded into the MMIS and are ready for adjudication immediately.
- Electronic claims cannot allow for attachments of any kind (other payer denial, clinical notes, etc.).
- Claims must be sent on paper if they have attachments of any kind (other payer denial, clinical notes, etc.).
- Paper claims (with or without attachments) are
  - scanned at the Williston office;
  - processed by an OCR by Gainwell (in Pennsylvania);
  - stored electronically (image) in OnDemand.
- The ICN's first two digits indicate the claim media:
  - 10 – paper; 11 – paper w/ attachment; 40 – electronic.

Adjudication Process:

- Claims will do one of three things:
  - 1. Automatically deny.
  - 2. Automatically be approved to pay.
  - 3. Suspend for manual review.

Notes:

For only claim type M, each line or "detail" is processed independently. For any given ICN (claim), line 1 could deny, line 2 could pay, and line 3 could suspend.

All other claim types are adjudicated as a whole; meaning there either is or is not a payment for the claim in its entirety.

Edits & Audits:

- During adjudication, claims will go through nearly 1000 edits and audits.
- Edits look at the information on the claim being adjudicated.
  - Is the date valid?
  - Is the provider # valid?
  - Does the member name and # match?
- Audits look at the information on the claim being adjudicated and another claim in the system for the same member.
  - Has this member had 5 office visits this month?
  - Has the member exhausted the allowed number of physical therapy sessions?

Claim Payment:

- Once a claim has been adjudicated (deemed to be paid or denied), the system assigns a paid date.
- The provider will receive information about the claim payment or denial on their remittance advice (RA) each week.
- The provider will receive a single payment for all of their claims each week.
  - If there are any recoupments, those are recovered by subtracting them from the payments.
  - The payments are nearly all done via EFT.

Claim Information:

- All claim information from a paper claim is viewable as the image is stored in OnDemand.
  - Note: OnDemand is being replaced with OnBase.
- *Most* of the information from the paper claim is read by the OCR and that is then saved in the MMIS AIM system.
- *Most* of the information from an electronic claim is saved in the MMIS AIM system.
- *Most* of the information (but not all) from the MMIS AIM system is also saved in EVAH for 10+ years.
- *Most* of the information (but not all) from the EVAH system is available via BusinessObjects for 10+ years.

Use Case Development

"A well-crafted use case communicates the functional requirements to inform the technical planning and identify all workflow modifications that will need to be implemented. Having this worked out first will help scope and develop the solution and accelerate the technical evaluation process.

Developing use cases requires understanding your business needs, i.e. the issues and opportunities to address. Defining the needs early in the process will accelerate the design effort and provide a basis to evaluate success."

-MeHI, Massachusetts eHealth Institute

Use Case Gathering Process

1) After the kick-off meeting, the HIE unit will work to schedule a 'Use Case Gathering' session with the Subcommittee members for their corresponding Organizations/Programs.
2) The use case gathering session will be conducted by our Subject Matter Expert (SME) and Business Analyst (BA).
3) Based on the initial set of responses, the HIE unit may request the Subcommittee Member for a subsequent interview session to gather more details. This may also involve additional stakeholder(s)/SME(s)/representatives from the Subcommittee member's team who are equipped in answering the questions for us to document all use case elements in a well-defined fashion.
4) The BA will document the use cases via the template and maintain a consolidated master list on a spreadsheet and share the draft use cases with the SME for review.
5) The BA & SME will revise the use cases based on the final set of feedback received.
6) Once the use cases are finalized, they will be presented to the Subcommittee for review and feedback.

Role of Subcommittee Members Re: Use Cases

- Learn about each of the use cases presented by fellow subcommittee members
  - What is the user trying to accomplish? What do they need?
- Weigh in: support editing, culling, prioritizing
  - How could this be augmented to be clearer? Is it missing anything? Where does this fit in your sense of priorities?
- Support assessment of technical feasibility by VITL and MMIS partners

Use Case Gathering Sessions

Interview	Focus of Discussion
Katie Muir, *OneCare VT*	• Evaluation & Reporting of the APM • Support of clinical practices and the care model
Katie Muir, *OneCare VT* **Erin Flynn, *DVHA Payment Reform***	• Evaluation & Reporting of the APM • Support of clinical practices and the care model
Lisa Schilling, *Medicaid Operation* **Erin Carmichael, *Medicaid Quality*** **Shawn Skaflestad, *Medicaid Performance Management/Improvement*** **Tim Tremblay, *Vermont Blueprint for Health***	• Quality Improvement and Reporting for Medicaid and the Blueprint • Overall evaluation of GC1115 waiver

Sarah Lindberg, *Green Mountain Care Board*	• Analytics for -
	  • evaluating the APM
	  • evaluating the Boards regulatory activities

Emma Harrigan, *VAHHS* **Lauri Scharf, *BiState Primary Care Assoc.*** **Thomasena E Coates, *Blueprint QI Facilitator***	• Point of care support

Use Case Examples

Claims Use Case Categories

1. Clinical – Individual
2. QI/Operations – Organization
3. Evaluation – Population
4. Reporting - Population

USE CASE: Select Category

Focus Area

ORGANIZATIONS

Describe your organization and its role in producing and/or using claims data.

GOAL

Describe goal(s) for use of clinical data extracts and/or unified clinical and claims data.

TRADING PARTNERS AND SYSTEMS

List systems and organizations (partners) that you rely upon to achieve the stated goal(s)

- Past & Current Prescription Claims Data - Source
- Past & Current Prescription Clinical Data - Source
- VHIE - Aggregate & Exchange Data
- Clinician/me - Destination
- Pharmacy - Source & Destination
- Patient - Destination

DATA TO EXCHANGE

Describe the information to be exchanged.
What data do you need?

DATA GOVERNANCE

To the best of your ability, describe the laws and/or processes that allow this data to be used by your organization and/or exchanged with other organizations. If there are none, describe what is needed to realize your data use goal.

USER STORY

Describe in story format:
The actors involved in this use case.
When, why, how the needed information will be used by the actors and their organizations

FREQUENCY

How frequently will the VHIE need an extract if that's the method?

USE CASE TARGET DATE

When do you need the data? Are you getting this Data today? If yes, how?

MMIS DATA PIPELINE (Source)

<Ask Tech Experts>

DATA FORMAT (Source to VHIE)

What format will the data be in if it's an extract?

TRANSPORT MECHANISM

How does the Data get to the VHIE?
SFTP for Extracts OR
API for Real Time

DATA RECIPIENT FORMAT (VHIE to End User)

TBD

CONSENT SPECIFICATIONS

Any consent specifications from Patient?

LEGAL AGREEMENTS

Do you know if a legal agreement is required (or exists) for your organization to use the data?

USE CASE: Clinical - Individual

Prescription Reconciliation, Fulfillment Monitoring

ORGANIZATIONS

Clinician in an Ambulatory Practice.
Ambulatory Practice will use the claims data.

GOAL

Improving Patient safety and outcomes by ensuring the Patient is taking clinically appropriate medication and avoiding harmful drug interactions

TRADING PARTNERS AND SYSTEMS

Other Clinicians seen by the Patient and pharmacies filling prescriptions provide prescription information to VHIE and that information is made available to me/Clinician via the EHR Interface that my Practice use.

- Past & Current Prescription Claims Data - Source
- Past & Current Prescription Clinical Data - Source
- VHIE - Aggregate & Exchange Data
- Clinician/me - Destination
- Pharmacy - Source & Destination
- Patient - Destination

DATA TO EXCHANGE

Past & Current Prescription Claims Data
Past & Current Prescription Clinical Data

DATA GOVERNANCE

HIPAA
VHIE Patient Consent Policy - Clinical
VHIE Patient Consent Policy - Claims ???

USER STORY

Actors: Clinicians and Patients e.g., Primary Care Physician, Specialist

Medication errors are a significant concern for patient safety especially without adequate reconciliation during a hospital discharge or when patients see multiple providers or use multiple pharmacies.

As a Clinician seeing a patient with poly-pharmacy needs,
I want to be able to view all the medications that the Patient has been prescribed and when those prescriptions were last filled,
So that this information, in addition to my conversations with the Patient, will allow me to determine whether the Patient is on the right medications and dosage, whether they are skipping appropriate medications, or whether there is any potential for harmful drug interactions.

As a Patient,
I want to be able to view all my medication records,
So that when I move between seasonal residencies, such as Florida and Vermont, I can provide this information to my local Provider who may not have access to my medication records

FREQUENCY

Real Time

USE CASE TARGET DATE

Now

MMIS DATA PIPELINE (Source)

<Ask Tech Experts>

DATA FORMAT (Source to VHIE)

Readable in my EHR OR available to my Practice, Preferably in FHIR

TRANSPORT MECHANISM

API

DATA RECIPIENT FORMAT (VHIE to End User)

TBD

CONSENT SPECIFICATIONS

TBD

LEGAL AGREEMENTS

TBD

USE CASE: Clinical - Individual

Validate the Service Provided

ORGANIZATIONS

Clinician in an Ambulatory Practice.
Ambulatory Practice will use the claims data.

GOAL

Validating a service was provided (e.g., colonoscopy/cancer screening) via a claim so that at the point of care a Clinician can use this information to support clinical decision making

TRADING PARTNERS AND SYSTEMS

Other Providers who have seen the Patient in the past provide the information to VHIE and that information is made available to me/Clinician via the EHR Interface that my Practice use

Past & Current Providers Claims Data - Source
Past & Current Providers Clinical Data - Source
VHIE - Aggregate & Exchange Data
Clinician - Destination

DATA TO EXCHANGE

Past & Current Prescription Claims Data
Past & Current Prescription Clinical Data

DATA GOVERNANCE

HIPAA
VHIE Patient Consent Policy - Clinical
VHIE Patient Consent Policy - Claims ???

USER STORY

Actors: Clinicians e.g., Primary Care Physician, Specialist

As a Clinician, having a patient's complete medical history, including previous procedures, helps me to make better recommendations for needed screening and care management. However, when reviewing a patient's history with the patient, his or her recollection can be incomplete; for example, he or she may not remember whether or when a preventive screening procedure, such as a mammogram or colonoscopy, took place. If I have access to both claims and clinical records, I can confirm or correct the patient's record and make more informed recommendations for future screenings. Additionally, if I need more information on the results of this procedure, this information will allow me to follow up with the provider who ordered the procedure.

As a Clinician,
I want to be able to access patient's complete medical history including previous procedures,
So that it helps me to make better recommendations for needed screening and care management.

FREQUENCY

Real Time

USE CASE TARGET DATE

Now

MMIS DATA PIPELINE (Source)

<Ask Tech Experts>

DATA FORMAT (Source to VHIE)

Readable in my EHR OR available to my Practice, Preferably in FHIR

TRANSPORT MECHANISM

API

DATA RECIPIENT FORMAT (VHIE to End User)

TBD

CONSENT SPECIFICATIONS

TBD

LEGAL AGREEMENTS

TBD

USE CASE: QI/Operations - Organization

Panel Management of Individuals with Chronic Conditions

ORGANIZATIONS

Ambulatory Care Practice
Ambulatory Care Practice/s will produce and use Claims Data

GOAL

Improve Panel management processes and patient outcomes.

TRADING PARTNERS AND SYSTEMS

Other Providers who have seen the Patient in the past provide the information to VHIE and that information is made available to me/Clinician via the EHR Interface that my Practice use

Past & Current Providers Claims Data - Source
Past & Current Providers Clinical Data - Source
VHIE - Aggregate & Exchange Data
Ambulatory Practice (Clinicians, Practice Managers, QI Facilitators) - Destination

DATA TO EXCHANGE

Past & Current Medical, Prescription Claims Data
Past & Current Medical, Prescription Clinical Data

DATA GOVERNANCE

HIPAA
VHIE Patient Consent Policy - Clinical
VHIE Patient Consent Policy - Claims ???

USER STORY

Actors: Clinicians, Practice Managers, QI Facilitators, Payers (?)

As a Practice/Panel Manager (Is this an appropriate title? Ask DVHA Clinical), I want to be able to identify all patients in my practice that have diabetes. Of that population, I want to know who has received regular screenings for complications related to diabetes, who has had regular testing for HbA1c levels, who is filling needed prescriptions, and who needs additional outreach or support for this care. Additionally, I want to see which patients have high A1c readings. Information contained in the claims and clinical data, as well as direct follow up, can help me determine whether those individuals are having trouble accessing the care they need or whether they need to adjust the current care regimen. With this information, I can individualize the type of outreach they receive. For example, some patients may need to modify medications they receive, while other patients may need help with transportation to make scheduled appointments.

The combination of claims and clinical data provide me with a more holistic view of the practice's patients with diabetes that allow me to make these panel management decisions.

Beyond direct care to patients, integrated claims and clinical data over time allow me to identify whether the practice's initiatives to improve quality of care were successful, or whether further improvements to the management of panels are necessary.

FREQUENCY

Real Time OR Monthly (May vary for different scenarios)

USE CASE TARGET DATE

Now

MMIS DATA PIPELINE (Source)

<Ask Tech Experts>

DATA FORMAT (Source to VHIE)

Readable in my EHR OR available to my Practice, Preferably in FHIR

TRANSPORT MECHANISM

Data Extract or API

DATA RECIPIENT FORMAT (VHIE to End User)

TBD

CONSENT SPECIFICATIONS

TBD

LEGAL AGREEMENTS

TBD

USE CASE: Evaluation - Population

Assessing Quality Improvement Initiatives on Hypertension Control and Outcomes

ORGANIZATIONS

State Analytics Team and/or ACO
Analytics Team will use the aggregated Claims and Clinical Data.

GOAL

Understanding whether the community-wide efforts to improve control of hypertension at the population level is effective at improving health outcomes and acute health care service utilization.
e.g., Emergency Dept. visits, inpatient, surgical procedures for Ambulatory Care Sensitive Conditions - ACSC

TRADING PARTNERS AND SYSTEMS

Past & Current Providers Claims Data - Source
Past & Current Providers Clinical Data - Source
VHIE - Aggregate & Exchange Data
Data user: State Analytics Team and/or ACO

DATA TO EXCHANGE

Past and current clinical data: blood pressure readings from clinical settings, recorded in EMRs;
Past and current claims data: diagnoses, procedures, and health service utilizations

DATA GOVERNANCE

HIPAA
Data provided as limited dataset OR deidentified data (does VHIE consent policy apply? Question to VITL Legal Rep)

USER STORY

Actors: Policy Makers, Payers, Clinicians

Uncontrolled hypertension can lead to serious health issues such as heart failure, stroke, kidney disease etc. Therefore, reducing incidence and improving control of hypertension is a priority of the state, as identified in the All-Payer ACO Model Agreement. The State of Vermont, through the Blueprint for Health, the Department of Health, and the State's Accountable Care Organization (ACO) supports and provides resources for community-wide efforts to improve the control of hypertension. These efforts include learning collaboratives to improve team-based care strategies, quality improvement initiatives to improve panel management of patients with hypertension, and self-management programs to support individuals who engage in their own well-being.

As an Analyst for the State,
I am interested to see whether these efforts and resources are improving the health of the regional population in terms of control of blood pressure and reduced acute health service needs related to hypertension.

Integration of claims and clinical data for the full community-wide populations allows the state to examine trends in control of hypertension (i.e., whether there is a significant increase in individuals with hypertension whose blood pressure is in the normal range) and decrease in acute care needs for conditions related to hypertension.

FREQUENCY

Biannual

USE CASE TARGET DATE

TBD

MMIS DATA PIPELINE (Source)

<Ask Tech Experts>

DATA FORMAT (Source to VHIE)

Readable in my EHR OR available to my Practice, Preferably in FHIR

TRANSPORT MECHANISM

Data Extract or API(Preferably in FHIR)

DATA RECIPIENT FORMAT (VHIE to End User)

TBD

CONSENT SPECIFICATIONS

TBD

LEGAL AGREEMENTS

TBD

USE CASE: Reporting - Population

Percent of Population with Hypertension in Control and Diabetes in Poor Control

ORGANIZATIONS

State Analytics Team and/or ACO
Analytics Team will use the aggregated Claims and Clinical Data.

GOAL

Reporting status and performance on key indicator 'Percent of population with hypertension in control' and 'Diabetes in Poor Control' for Payment, State and Federal oversight purposes; measures typically negotiated prior to implementation.

TRADING PARTNERS AND SYSTEMS

Past & Current Providers Claims Data - Source
Past & Current Providers Clinical Data - Source
VHIE - Aggregate & Exchange Data
Data user: State Analytics Team and/or ACO

DATA TO EXCHANGE

Past and current clinical data: blood pressure readings from clinical settings, recorded in EMRs;
Past and current claims data: diagnoses, procedures, and health service utilizations

DATA GOVERNANCE

HIPAA
Data provided as limited dataset OR deidentified data (does VHIE consent policy apply? Question to VITL Legal Rep)

USER STORY

Actors: Federal and State Oversight Bodies e.g., CMS

As an Analyst for the State, I am responsible for reporting to federal oversight bodies results for agreed upon measures. Two priority measures include controlling high blood pressure, which assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg, NQF 0018); and assessing those with diabetes in poor control (percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period, NQF 0059). Both measures require both clinical and claims data to produce an outcomes, and the ability to automatically integrate this data without having to do chart reviews would be beneficial to both analysts, who would have access to a broader sampling on the patient population and the practices who do not have work with analysts to conduct chart reviews.

As an Analyst for the State,
I want to be able to access and use the aggregated Claims and Clinical Data,
So that I can report to federal oversight bodies the results for agreed upon measures i.e., 'Percent of population with hypertension in control' and 'Diabetes in Poor Control'

FREQUENCY

Biannual

USE CASE TARGET DATE

TBD

MMIS DATA PIPELINE (Source)

<Ask Tech Experts>

DATA FORMAT (Source to VHIE)

Readable in my EHR OR available to my Practice, Preferably in FHIR

TRANSPORT MECHANISM

Data Extract or API(Preferably in FHIR)

DATA RECIPIENT FORMAT (VHIE to End User)

TBD

CONSENT SPECIFICATIONS

TBD

LEGAL AGREEMENTS

TBD